DATALINK

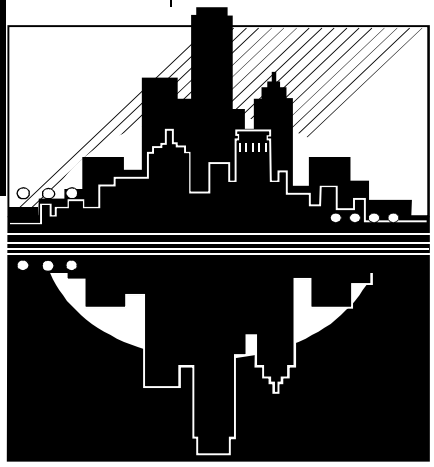
Your link to the Centralized Credentials Process & Database

To keep you knowledgeable about current and emerging developments within your areas of expertise for the purpose of enhancing your professional development

Volume 1 Issue 3 ***October 1997***

MILITARY EXEMPT LICENSURE

Warning! Do not go to GQ over this issue..the following is for information only.



Currently, Military Exempt licensure status is still recognized by the DoD. However, there are certain problems associated with this licensure status: (1) There is some discussion as to what the term "military exempt" means and, (2) across the United States, the term "military exempt" means something different in each state depending upon state statutory law. In some states where this license is recognized, this term means the provider is a licensed independent practitioner who is licensed to work in a military (government) health care facility; but,

FOR OFFICIAL USE ONLY
Copies authorized for internal distribution
Editor: CDR G. Irvine, Code OOA
Published by HSO, Jacksonville, FL. 32212-0140

cannot practice in the state of issue, until certain fees have been paid. In other words, a practitioner with a military exempt license **can** practice in **any** military health care facility. Should the practitioner desire to "moonlight" at a civilian facility anywhere in the issuing state, there may be additional state requirements needed to covert the military exempt license into a regular license. Until this is done, the practitioner cannot practice in a civilian facility in the issuing state.

Licensure Criteria

Current DoD (Navy) policy calls for a license to meet certain criteria: (1) Current: Active, not revoked, suspended, or lapsed in registration; (2) Valid: One to which the issuing authority accepts, investigates, and acts upon quality improvement information (PI data); and, (3) Unrestricted: Not subject to limitations on the scope of practice. In the past, Navy PACs did not "quiz" the state as to what the term military exempt meant...it was usually taken for granted a state's military exempt license met the Navy's license criteria. Over the past several years, we have found this is not so. An additional difficulty is when the state calls the military exempt license by a different term, e.g. "special" license, and tells the PAC this is the license the state issues to it's military practitioners if requested.

Primary Source Verification (PSV)

The best defense we have to protect our patient's safety, and assure our patients get quality care, is to know exactly what the state means by "military exempt." As experts in the credentials field, we must specifically **ask** the state medical licensing board these questions during the PSV process (document either the phone conversation or get it in writing):

a. Is this license status current...active, not revoked, suspended, or lapsed in registration since original issue?

b. Is this license status valid...one to which QA, PI, CQI (whatever the current terminology is for QA information) accrues?

c. Is this license status unrestricted...not subject to any limitations on the scope of practice? The state not allowing the practitioner to practice in the state until further criteria was met, was not considered a restriction (after all, this was the very essence of the military exempt license). This may change. DoD may further delineate the term "unrestricted" to mean...the military exempt license must also allow the practitioner to practice in the issuing state. It is conceivable, this will mean the end to the military exempt license as we know it.

.

In Conclusion

The issue of "military exempt" licensure is being discussed again. **No action has been taken.** Until a decision has been made, one way or the other, we will continue as we have in the past with one exception: *On all military exempt and any other "special" or different licensure status, the PAC will do a specific primary source verification addressing the questions above; and, document completely the conversation exchange.*

I will keep you informed of further action(s) and/or decisions regarding this issue.

OKLAHOMA STATE "SPECIAL" LICENSURE STATUS

Special PAC Alert!!!

Oklahoma Law Changes

State statutory licensing laws are not static...state laws frequently change. It is difficult for the individual PAC to keep current with the many changes that do occur.
When these changes directly affect the licensing status of the practitioner, the state will forward a letter to the individual practitioner; but, there is no requirement for the state to notify the Navy. Often we learn of these changes through our practitioners upon renewal of licensure.

PSV of Current Licensure

Upon granting the Initial Staff Appointment, the current license must be fully PSV'd. The Joint Commission states upon **reappointment** and at the time of **renewal** or revision of clinical privileges, current licensure is confirmed with the primary source **or** by viewing the applicant's current license (and placing a copy of the license in the ICF/IPF).
It is extremely important at the time of reappointment to the medical staff, if you do not complete a PSV, but only view the license, you must ***compare the license with previous licenses before you place it in the ICF/IPF.***

Additionally, ask the provider if he/she has received any correspondence from the issuing state regarding any changes in the state licensing laws. Following the above recommendations may help us avoid the following situation that recently occurred.

Changes in the Oklahoma Licensing Law

On 1 July 1995, the state of Oklahoma's Allopathic Board revised the Medical and Surgical Licensure and Supervision Act. I will not go into all of the details (100 pages worth). The outcome was...military practitioner's valid state licenses, upon individual state review, were changed to a "special" status that did not meet Navy's license standards. These "special" licenses were not picked up until a few months ago, because no one was aware of the change. The practitioners did not inform the PACs of the change because they probably did not understand the ramifications resulting from the change. The renewed license looked exactly the same except for one small word "special" located on the license. The PACs did not pick up on this change as they placed a copy of the renewed license in the ICF.

Plan for Improvement

The importance of licensure status at time of renewal of staff appointment cannot be overlooked. Currently, the Joint Commission allows for the "viewing" of the current license at this time. However, **viewing is not enough**. Be meticulous in your attention to detail...copy this license and compare it to the other licenses, closely. Ask the provider if they have received any state licensure correspondence within the past two years regarding licensing changes. If they have, request a copy for your review. Do not assume the renewed license is the same license that was verified years...ago. If there are any questions regarding the licensure, contact CDR G. Irvine immediately so we can work through the issue.
If you have any additional questions regarding PSV of licensure, anytime within the credentials process timeline, please contact me.

PSV LICENSURE VIA STATE INTERNET WEB SITE

There are many inquiries asking if licensure PSV, via the state Internet Web Page, is consistent with Navy standards. This issue was discussed and several state Web pages were reviewed. The decision: Until state Web pages are more consistent in their methodology and information available, PSV via the state Internet Web page does not meet Navy standard. While we realize the potential use of this vehicle for our operational and overseas facilities, the data across the Web pages is inconsistent, and in most of the states, you cannot confirm the standing of the license, nor if it voluntarily or involuntarily expired or lapsed (the state would have to be called or written anyway). The money saved for partial information is not worth the potential negative future ramifications.
As the state Web pages improve and the data becomes increasingly consistent across the board, the use of the state Web pages will be reconsidered.

CLINICAL PERTINENCE

REVIEW:

REVISITED

The Navy has a habit of using peer review and clinical pertinence review interchangeably (as was in the last DATALINK). HSO Norfolk forwarded to me a copy of a publication titled *Clinical Pertinence Review...Winning Strategies for your JCAHO* Survey, 1966, Opus Communications. Here are some excerpts from the article: "Clinical Pertinence review, or regular review of medical record documentation, is an activity required by the JCAHO. The JCAHO, however, no longer uses the term clinical pertinence review, and simply refers to a review of medical records in its standards. The term is confusing. To some, the term connoted a review of medical records to evaluate adequacy of treatment...but, in fact, clinical pertinence review is simply a review of medical records to evaluate the quality of the records themselves." It is a multidisciplinary task, not one of strict peer review.
I hope this clarifies any lingering confusion as to the usage of the term "clinical pertinence review." For any additional information please consult with your Performance Improvement Coordinator.

CREDENTIALS AND PRIVILEGING ANNUAL TRAINING (AT) GUIDANCE

HMC MICHAUD'S CORNER

In May 1997, a message was promulgated from the Commander, Naval Reserve Force, New Orleans. It set forth guidance for the processing of AT applications for medical personnel for whom credentials and privileging is required. It sets forth the following guidance:

a) Upon receipt of an AT application on a medical department member, the AT Coordinator shall contact the Reserve Liaison Officer (RLO) at the gaining command to request a billet control number (BCN).

b) The RLO will obtain all required information and inform the AT Coordinator that credentials and privileges require verification.

c) The RLO must call the CCPD and verify if the Reservists credentials and privileges are current and in good standing.

d) The RLO will notify the AT Coordinator of any discrepancies that require correction or issue a BCN for the member.

Therefore, it is the RLO's responsibility to ensure credentials will be current for the AT requested by the RESCEN, and then a BCN be issued to allow for the AT application to be processed. This process should eliminate any Reservists reporting to your command without the appropriate credentials/privileges.
The RLO and the individual PAC at every command must work together to ensure the credentials information is fully researched prior to the granting of the BCN for the command. The CCPD cannot be responsible for the Reservist reporting aboard for AT who has not been through the appropriate channels.
As of 1 October 1997, the CCPD will require a faxed memo of explanation, from the RLO, addressing the reason why an "emergency CTB" is being requested from the PAC office. This is to reduce the chances of an "unscheduled" provider reporting to the PAC office expecting

to practice at the command. Providers reporting to your command for AT, without your being notified, need to be further investigated by the COMNAVRESFOR via the RLO.

HSO CREDENTIALS & PRIVILEGING CONFERENCE

ATTEND ONE...ATTEND ALL!!!

What? PAC Credentialing and Privileging Conference: Getting Down to the Nuts and Bolts of the Credentials Process

Date: 4 - 6 Nov 1997 3 full days, plan to travel on Friday.

Where: Officers Club (O Club) on NAS Jacksonville, FL

Agenda: CCQAS 1.0/2.0 presentation; MS Leadership Responsibilities; Overview of Navy Credentials Process; Adverse Action Process; PAC Peer Review Panel Responsibilities; Operational Issues & Privileging, CCPD Panel Discussion; Initial Appointment Process; Reappointment Process; ICTB/Q Process; 6320.66B Update; Typical Type I Recommendations; Managed Care Impact on Credentials Process; Case Studies. And of course, whatever **you** want to ask, discuss, inquire, or present.

Registration: If you have not registered, contact jax0slb@jax10.med.navy.mil or

phone: 904-542-7200 Ext 8142 DSN 942-7200 Ext 8142.

JCAHO TOUGHENS MEDICAL STAFF STANDARDS

Per *Briefings on Credentialing*, a newsletter published by the Credentialing Resource Center, the JCAHO is "turning up the heat" on several medical staff standards.

Sixteen standards previously capped at 2 are moving into a potential Type I territory the higher you go the worse it gets!). Many of the medical staff standards could not be scored lower than a 3 (an automatic Type I)...now they may be scored as high as 5 (the worst possible score). This change will impact hospitals particularly those seeking to achieve accreditation with commendation.

Single, Organized Medical Staff

The only medical staff standard to actually be revised is: the standard requiring hospitals to have a single, organized medical staff. Health care organizations have more freedom to determine medical staff structure. Because of mergers and consolidations, the standard allows when separate medical staffs within a single hospital may exist if they provide care to separate patient populations at geographically distinct sites (this will affect the civilian community). The JCAHO has set criteria to determine whether a hospital has more than one

medical staff (if you want the criteria, let me know).

Director of the JCAHO's department of standards, stated a possibility the JCAHO may publish a separate medical staff standards manual in the future, 1999. A work group will study this issue.

Medical Staff Standards Moved from Cap 2 to 3

A Score 2 means *significant compliance* with the JCAHO standard. A Score 3 means *partial compliance* and is usually an automatic Type I recommendation for your organization. The following medical staff standards were moved into potential Type I territory:

MS.2.3.4 - What the MS bylaws must include.

MS.2.3.4.1 - Bylaws definition

MS.2.3.4.1.1 - Methodology for selecting MS officers.

MS.2.3.4.1.2 - Quals, responsibilities, tenures of MS officers

MS.2.3.4.1.3 - MS officer removal from their leadership positions

MS.3.1.6 - ECOMS/ECODS responsible to the governing board for MS recommendations

MS.3.1.6.1; MS.3.1.6.1.1; MS.3.1.6.1.2; MS.3.1.6.1.7 - Conditions of recommendations to the governing body and what must be included

MS.5.4.4; MS.5.4.4.1; MS.5.4.5 - Decisions on appointment, reappointment or on any adverse action must be based on criteria directly related to the quality of care; subject to fair hearing and appeal process

MS.5.8.1 - One individual credentials file (ICF)

MS.6.3 - Standards regarding those nonpatient services (ambulatory surgery) requiring a medical history and examination

MS.7.1; MS.7.1.1; MS.7.1.1.1; MS.7.1.1.2 - Hospital sponsored educational activities are related to type and nature of care provided, and the findings of PI activities

MS.8.5.2 - Mechanism for documenting permission to perform an autopsy is defined

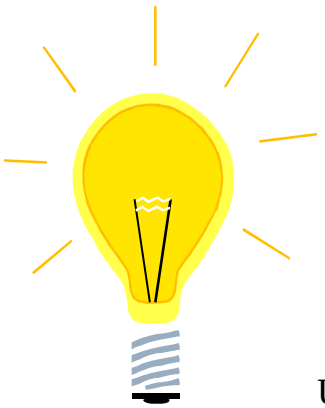
MS.8.5.3 - System for notifying the MS, specifically the attending practitioner, when an autopsy is being performed (**changes from 2 to 5)**.

If you have any additional questions you can discuss the above with the PI Coordinator at your facility.

SELECTED RESERVE INDIVIDUAL ICF/IPFS WHO ARE ALSO CONTRACTED INDIVIDUALS AT SAME FACILITY

A letter, 6320 Ser 32\0214 of 1 Aug 97, was forwarded to all Commanding Officers regarding the disposition of the ICF/IPF for all Selected Reservists. The letter in essence states the following: "The CCPD in the HSO, Jacksonville, is the repository for all SELRES ICF/IPFs. Inclusive are SELRES who work in a Navy facility as CIVIL SERVICE, CONTRACTED, and PARTNERSHIP providers. This is also contained within the BUMEDINST 6320.66B." The CCPD is missing several files for continuous management and maintenance...please send these files to the CCPD ASAP. POC for this issue is (904) 542-7200 ext. 8116.

REMEMBER!!!!



Until CDR Irvine figures out how to remove the extra pages in this DATALINK template, set your printer to print 7 pages! I will figure it out sooner or later. If anyone has any ideas.....